MEDICAL REPORT PART 1

N.B. - TO BE COMPLETED BY APPLICANT

NAME: ____ AGE __________________________

SEX: MALE _________FEMALE __________

MARITAL STATUS: MARRIED ______ SINGLE ________ DIVORCED _______ WIDOW__________

ARE YOU PRESENTLY IN GOOD HEALTH? ___________________________________

HAVE YOU EVER BEEN ADVISED TO UNDERGO OBSERVATION, TREATMENT OR OPERATION FOR ANY DISEASE OR ACCIDENT? YES ________ NO ______

IF YES, PLEASE SPECIFY ____

____

ANY PERMANENT DISABILITY? YES __________ NO ___________

DO YOU SUFFER FROM

(a) SEVERE HEADACHES? _______________

(b) FAINTING SPELLS? __________________

(c) ANY CHRONIC DISCHARGE FROM EARS __________

(d) VISUAL IMPAIRMENT NOT CORRECTED BY GLASSES?

____

(e) CHRONIC COUGHS? _____________________________

(f) SHORTNESS OF BREATH? ________________________

(g) SINUSES? ______________________________________

(h) HEART TROUBLE _______________________________

(i) ALLERGIES ____________________________________

(j) SKIN CONDITION ______________________________

(k) ABDOMINAL DISCOMFORT _______________________

(l) URINARY DIFFICULTY __________________________

(m) R.H. ____

(n) ANY OTHER COMPLAINT NOT MENTIONED

____

____

(o) IF FEMALE, IS YOUR MENSTRAL FUNCTION REGULAR

___________ AND NORMAL? _____________

FAMILY HISTORY:

(A) WHAT DEATHS OR ILLNESSES HAVE THERE BEEN IN YOUR FAMILY?

____

(B) INDICATE DATE, CAUSE OF DEATH OR ILLNESS, IF ANY

____

APPLICANT'S SIGNATURE: ______________________________________ DATE:______________